APPENDIX D

INCAPACITATION PAYROLL TRANSMITTAL

HHB, 2d Bn 144th FA (unit) 8 May 1989 (date)

MEMORANDUM FOR Office of the Adjutant General, ATTN: CAMP-SB, P.O.Box 214405, Sacramento, CA 95821-0405

SUBJECT: Request for Approval of Incapacitation Pay

1. Request incapacitation pay for PFC John J. Doe

SSN 001-22-0345 be approved from 7 May 1989 to 20 May 1989

based on an injury/disease incurred on 23 April 1989

2. Soldier attended training since disability occurred on the following dates: NONE

3. Soldier's MOS/SSI and title when disabled. 13F10 Fire Support Specialist

4. Enlisted soldier's ETS date: 3 Oct 1993 .

5. Civilian employer (indicate if unemployed): Long Beach Naval Shipyards, Long Beach, CA Occupation: Pipefitter

6. Date returned or expected to return to duty:

Military 21 May 1989 Civilian 21 May 1989

7. Address to which check is to be mailed: PFC John J. Doe

1289 Sheild Drive, Norwalk, CA 92050

8. I certify that, during the period indicated in 1 above, the incapacitation of this soldier prevented him/her from performing the duties of his/her MOS/SSI . Verification of civilian income earned and/or lost is attached.

x Curtis M Kelley
(unit commander)
CURTIS M. KELLEY
CPT, FA, CA ARNG
Commanding

Encl check list
CAL NG Form 37-2H
CAL NG Form 37-2E/2F
CAL ARNG Form 40-6-2
check stub
DA Form 2173/CAL ARNG Form 2173
CAL NG Form 37-D
orders/training schedule

CAL NG Form 37-2C

APPENDIX D (continued)

ADAPS PAYROLL CERTIFICATE

NAME: John J. Doe RANK: PFC/E3 UNIT: HHB, 2/144th FA

TL NUMBER: N/A ACN: N/A DATE RECEIVED: N/A

SSN	PRN	ORDERS NUMBER	ORDERS DATE (Y Y M M D D)
001220345	-N/A-	---N/A-	--NA--

	START DATE (Y Y M M D D)	END DATE (Y Y M M D D)	STATE TAX	ENL BAS	ENLISTED BAS DYS	SBAQ	TVL DAYS
1	890507	890520					
2							
3							
4							

SFD	MILEAGE	VHA		SGLI	OPT	MODE	TDC	SUB

ADDRESS LINE 1 (NUMBER & STREET)

1289 Sheild Drive

ADDRESS LINE 2 (APARTMENT, SUITE, C/O ETC)

ADDRESS LINE 3 (CITY) STATE ZIP CODE

Norwalk CA 92050

LEAVE (COMPLETE IF REQUESTING PAYMENT OF ACCRUED LEAVE):

1. _____ DAYS EARNED (_____ TO _____) LESS _____ DAYS TAKEN = ACCRUED LEAVE _____ DAYS
2. DAYS ACCRUED LEAVE PAID SINCE 10 FEB 76 _____ (60 DAYS MAXIMUM)

MISCELLANEOUS ENTITLEMENTS: _____

SUPPLEMENTAL (USE TO CORRECT/CHANGE PAY RECEIVED). STATE PROBLEM, BE CONCISE:

CERTIFICATION OF PERFORMANCE (CHECK ONE):

☐ 1. I certify that I have personal knowledge or I have personally verified the duty requested above has been performed. If the date(s) of performance are different than originally requested, I have entered the correct day(s) of duty and have requested amendment of order.

☐ 2. The individual indicated above has or will report for duty in accordance with competent orders and, upon completion of the duty, is due pay and allowances in the grade and status shown. Any change affecting pay that accrues from this date to the ending date of the duty will be immediately reported to the USPFO. Checks for this duty will be delivered to the individual not earlier that the last day of duty by an agent who has knowledge of or has verified performance of the duty.

8 May 89 (DATE OF CERTIFICATION)

x CURTIS M. KELLY (PRINT OR TYPE NAME/SIGNATURE)

CHECK: ☒ COMMANDING OFFICER ☐ SENIOR SOLDIER PRESENT

CAL ARNG Form 37-9 REV 1 May 87

Original - USPFO
Copy - Unit

Previous Editions will be used until exhausted

APPENDIX D (continued)

SOLDIERS CLAIM FORM Reference CAL ARNG Pam 40-2	NAME: PFC John L. DOE	SSN: 001-22-0345

INSTRUCTIONS: All incapacitated soldiers are required to prepare this form monthly. It must be included with each incapacitation payroll submitted for payment. Complete the section that pertains to your case: Section 1. - Employed Section 2. - Unemployed Section 3. - Self-Employed Section 4. - All

SECTION 1. - EMPLOYED SOLDIER

1. I herby certify that I incurred/aggravated the following injury/~~disease~~: sprain right wrist in the line of duty while participating in military training/traveling directly to/from military training.

2. I further certify that as a result of the above described injury/disease, I suffered a loss of $ 800.00 of civilian income during the period 7 May 1989 to 20 May 1989 (period may only be one calendar month or less for each statment).

3. My claim is substantiated by the enclosed letter(s) from my employer(s).

4. In addition, I certify that I received $ -NONE- from an income protectin plan (including sick leave, etc.). NOTE: If the soldier does not have sick leave, vacation pay, or any other income protection insurance pay, he/she must so state.

SECTION 2. - UNEMPLOYED SOLDIER

1. I herby certify that I incurred/aggravated the following injury/disease: _____ in the line of duty while participating in military training/traveling directly to/from military training.

2. I further certify that I am unemployed at present, without income from any source, including, but not limited to, unemployment compensation, social security, workman's compensation or Veteran's Administration payments. If I become employed, while receiving incapacitation pay, I understand it will be my responsibility to notify my unit and/or commander to ensure military pay and allowances will be reduced by the income being received at that time.

SECTION 3. - SELF-EMPLOYED SOLDIER

1. I herby certify that I incurred/aggravated the following injury/disease: _____ in the line of duty while participating in military training/traveling directly to/from military training.

2. I further certify that as a result of the above described injury/disease, I suffered a loss of $ _____ of civilian income during the period _____ to _____ (period may only be one calendar month or less for each statment). I received $ _____ in gross income from being self-employed for the period above.

3. I am self-employed and in order to substantiate my claims of lost civilian income for the period cited in paragraph 2 above, I have enclosed a copy of my latest IRS Form 1040 with supporting documents including schedule c.

4. In addition I certify that I received $ _____ from an income protection plan (including sick leave, etc.) NOTE: If the soldier does not have sick leave, vacation pay, or any other income protection insurance pay, he/she must so state.

SECTION 4. - ALL CLAIMANTS

1. I further certify that the information which I have provided regarding this claim is correct. I understand that the penalty for knowingly and willfully making a false claim or a false statement in connection with a claim is a fine of up to $10,000 or imprisonment for up to 5 years or both. (18 USC 287, 1001)

2. I hereby waive my VA compensation. DA Form 3053 and VA Form 21-8951 are enclosed.

3. Privacy Act statement is enclosed.

DATE:	SOLDIER'S SIGNATURE
8 May 1989	John L Doe

CAL NG Form 37-2H

APPENDIX D (continued)

DISABILITY STATEMENT AND COMPLETE REPORT OF ATTENDING PHYSICIAN

Note to attending physician: Please complete the statement below if this Guard member is incapacitated and cannot perform normal military duties. To help you make that determination, the individual's normal military duties are outlined below:

(to be completed by unit prior to submission to physician)

Normal military duties for: 13F10 Fire Support Specialist
(Service member's MOS)

Consist of the following: Be able to walk, run, squat, crawl and fire a weapon.

Be totally able to work with no restrictions in a field environment.

I have examined PFC John J. Doe, 001-22-0345 (Name and SSN) on 23 April 1989 (Date)

Disabled from 23 April 1989 (Date) to 20 MAY 1989 (Date).

Date expected to return to normal military duty: 21 May 1989
(without limitation)

Cause of disability: Right Wrist Sprain
(Final Diagnosis)

Type medical treatment furnished: Splint, anti-inflammatory medication, limited duty, ice & elevate in evenings

Nature of healing process (prognosis): Good - Full Recovery expected - Return To Full Duty 4 weeks.

Is it in the best interest of the Federal Government to continue medical treatment rather than to place the service member before a Medical Evaluation Board? yes X no ____

This individual ~~(is)~~* (is not)* permanently disabled. If permanently disabled or if temporarily disabled for more than 90 days, the individual ~~(has)~~* (has not)* been scheduled for a (Medical Evaluation Board)* (Physical Evaluation Board)* in accordance with AR 40-3.

Board date: N/A

Current medical profile: (by service physician)

P	U	L	H	E	S
1	T3	1	1	1	1

John C. Smith, MAJ, MC
(Physician's Signature)

23 April 1989
(Date Signed)

John Q. Smith, MAJ, MC
LIC # 28460921
(Typed or printed name of physician and medical treatment facility)

*Strike out inapplicable term

(THIS FORM IS AFFECTED BY THE PRIVACY ACT OF 1974)

AUTHORITY: 32 USC 318 and 319: 37 USC 204(h); Sections 340 and 341, California Military and Veterans Code.

PRINCIPAL PURPOSES: To verify member's disability caused by service connected injury or disease. To determine final diagnosis. Social Security Number is used for identification.

ROUTINE USES: Used within the California Army National Guard to determine eligibility for disability pay and treatment in a service hospital or at government expense. Used to determine final diagnosis in line of duty investigations and determinations. Used by State Compensation Insurance Fund as an agent of the State of California to verify entitlement to State Compensation when federal benefits are delayed.

DISCLOSURE IS VOLUNTARY: Failure of member or his physician to provide requested information may result in delay in payment for incapacitation or delay in final disposition of member's case (Comp Gen decision #B-185404, 2 Aug 76).

CAL ARNG Form 40-6-2 1 Nov 88 **Replaces CAL ARNG Form 40-6-2 17 Feb 88**

APPENDIX D (continued)

E M P L O Y E R S T A T E M E N T

INCAPACITATION PERIOD: From 7 May 1989 To 20 May 1989

EMPLOYEE

I, John L. Doe (Typed Name), 001-22-0345 (SSN) hereby authorize the release of the information requested below.

John L. Doe 8MAY89
Employee's Signature Date

EMPLOYER CERTIFICATION

1. During the period indicated above the amount of gross compensation (wages, tips, commissions, ect.) this employee earned was $ -0-. The amount lost because of the disability is $ 800.00 (gross).

2. The amount paid, if any, by an income protection plan, sick leave or advance sick leave or vacation program during this period was $ NONE (gross).

3. I understand that this information is being used by the claimant as the basis of a claim against the United States. I further understand that knowingly and willfully assisting a claimant making a false claim or false statement in connection with a claim is a criminal offense under Federal and State laws which may subject the parties to a substantial fine and/or lengthy imprisonment.

Date signed: 8 May 1989

Paul W. Jones
(Official Signature)

Supervisor, Pipefitter Division
(Title/Position)

Long Beach Naval Shipyards
(Company Name)

Long Beach, CA 90822-5099
(Address)

(City)

(213) 547 - 6149 ext: 8011
(Telephone Number)

REMARKS:

CAL NG FORM 37-2E

APPENDIX D (continued)

EARNINGS AND LEAVE STATEMENT DA FORM 2790, 1 JUL 73 (AR 37-105)

★U.S. GOVERNMENT PRINTING OFFICE: 1985-485-407

CONTROL NO.	COST CODE	EMPLOYEE NAME	SH	CAT CODE	LV CAT	FT EX	SOCIAL SECURITY NO.	PAY PD END MO	DAY	YR
U81		JOHN L. DOE GR04-1	1	4	6	M03 M03	001-22-0345	04	21	89

EARNINGS

BASE HOURS	OT HOURS	ND HOURS	HOLIDAY HOURS	CD	OTHER HOURS	RATE
.00		0	.00		50	10.00

DEDUCTIONS

RETIREMENT	FICA	FEDERAL TAX	HEALTH BENEFITS	GROUP LIFE
00 .00	80098 24.29	56277 64.70	00 .00	.00

BOND

PUR CD	BALANCE
	.00

PAY

BASE PAY	OT PAY	ND PAY	CD	OTHER PAY	GROSS PAY	STATE TAX	CITY TAX	CD	OTHER DED	UNION DED	BOND DED.	NON-TAX PAY	NET PAY
.00	00 .00	.00		323.50	1066590 800.00	96.00	00.00		.00	15.00	.00		600.01

LEAVE

ANNUAL LEAVE: PRIOR YEAR BALANCE	ANNUAL LEAVE: TAKEN TO DATE	ANNUAL LEAVE: ACCRUAL TO DATE	ANNUAL LEAVE: MAXIMUM CARRY OVER	ANNUAL LEAVE: USE BY END OF YEAR OR FORFEIT	SICK LEAVE: PRIOR YEAR BALANCE	SICK LEAVE: TAKEN TO DATE	SICK LEAVE: ACCRUED TO DATE	CD	OTHER LEAVE TAKEN
56	120.0	120	240	.0	32	50	80		

* LEAVE BALANCE AS OF END OF THIS PAY PERIOD

ANNUAL	SICK	LWOP FOR YEAR	LWOP SINCE LAST INC.	COMPENSATORY	MIL LEAVE USED THIS PAY PERIOD
56	62	40.00		.00	BAL .00

OTHER EARNINGS CODE

1. HOLIDAY
2. LUMP SUM LV
3. LSL AND HOL
4. CASH AWARD
5. OTHER

OTHER DEDUCTIONS CODE

1. QTRS
2. SUBS
3. QTRS & SUBS
4. UTILITIES
5. DEL TAX
6. LSL REPAY
7. PL 86-604
60-69 UNION DUES
9. OTHER

SHIFT CODE

1. 1ST OR DAY SHIFT
2. 2D SHIFT
3. 3D SHIFT
5. SPLIT SHIFT

FRACTION CODE

2 1/4 HOUR
5 1/2 HOUR
7 3/4 HOUR

OTHER LEAVE TAKEN

H - HOLIDAY
C - COURT
O - OTHER

BOND PURCHASE

1. $ 18.75
2. 37.50
3. 75.00
4. 150.00
5. 375.00

* *Amount preceded by a minus sign indicates leave owed Government*

APPENDIX D (continued)

DISABILITY COUNSELING STATEMENT

I, the undersigned have been counseled on this date, in order to be eligible for continuance of pay and allowances while disabled from an injury or disease in the line or duty that:

1) I must promptly report to my unit when in need of medical or hospital care

2) I cannot seek private medical or hospital care without first obtaining authorization from my unit except for emergency medical care (the request will be processed by my unit for final approval to State Headquarters, CAMP-SB, or National Guard Bureau, NGB, IAW NGR 40-3).

3) I must report without failure to any medical appointment scheduled by my unit or by the doctor treating my condition unless prohibited by another physician from traveling. A statement from prohibiting Doctor is required.

4) I must cooperate fully with the medical personnel providing treatment.

5) I must furnish to my unit, upon completion of each of my medical appointments, the results of that appointment and the date of my next appt.

6) After each monthly visit to military Doctor/Civilian Doctor, I must furnish following statement to my unit:

NOTE: If I go to a civilian doctor without first obtaining approval from my unit, and they must then obtain approval from State Headquarters (OTAG), I must pay the medical bill myself.

a. A statement from the doctor (the CAL ARNG Form 40-6-2) stating that he examined me for that month and showing my condition for that month.

b. I must provide a monthly statement of employment from my employer, to include name, address, telephone number, point of contact, dates worked, position held, and hourly, weekly, or monthly rate of pay. Also, I must provide a copy of my payroll check stub. If self-employed, I must provide a statement of earned income to include a copy of my last Tax form filed with the Internal Revenue Service (all forms). Example: Form 1040 and Schedule C Form 1040, Profit or Loss From Business or Profession to include regular (Form 1040) monthly/weekly/daily record and/or other acceptable proof of earned income, and proof of self employment to include a copy of business license (if appropriate).

7) I further understand that failure to fulfill the above requirements may result in stopping my entitlements for pay and allowances for this disability

8) I WILL REPORT ALL INCOME TO MY UNIT IF I REQUEST INCAPACITATION PAY.

9) I further understand the penalty for willfully making false statements is maximum fine of $10,000 or maximum imprisonment of 5 years or both. (U.S. Code, Title 18, Section 287)

Date 8 May 1989 Signature John L Doe

Name of Counselor/Witness SSG Mary V. Greenwood

DISTRIBUTION:
Original - Unit
Copy - Individual Concerned
Copy - OTAG (CAMP-SB)

CAL NG FORM 37-D

APPENDIX D (continued)

STATEMENT OF MEDICAL EXAMINATION AND DUTY STATUS

For use of this form, see NGR 600-3; the proponent agency is The State Military Department

THRU: (Include ZIP Code)	TO: (Include ZIP Code)	FROM: (Include ZIP Code) (818)447-1144
CHANNELS	OTAG (CAMP-SB) P.O. Box 214405 Sacramento, CA 95821-0405	HHB 2d Bn 144th FA 260th W. Huntington Drive Arcadia, CA 91006-3401

1. NAME OF INDIVIDUAL EXAMINED (Last, First, and Middle Initial)	2. SSN	3. GRADE
DOE, John J.	001-22-0345	PFC

4. ORGANIZATION AND STATION	5. ACCIDENT INFORMATION	
	a. DATE	b. PLACE (City and State)
HHB, 2d Bn 144th FA Arcadia, CA	23 Apr 89	Camp Roberts, CA

SECTION I - TO BE COMPLETED BY ATTENDING PHYSICIAN OR HOSPITAL PATIENT ADMINISTRATOR

6. INDIVIDUAL WAS ☒ OUT PATIENT ☐ ADMITTED ☐ DEAD ON ARRIVAL

7. NAME OF HOSPITAL OR TREATMENT FACILITY ☐ CIVILIAN ☒ MILITARY
Silas B. Hayes ACH, Ft. Ord, CA

8. HOUR AND DATE ADMITTED
N/A

9. HOUR AND DATE EXAMINED
1530 23 Apr 89

10. DIAGNOSIS AND EXTENT OF ☒ INJURY ☐ DISEASE ☐ RESULTING IN DEATH (Explain)
Sprained Right Wrist

11. MEDICAL OPINION: a. INDIVIDUAL ☐ WAS ☒ WAS NOT UNDER THE INFLUENCE OF ☐ ALCOHOL ☐ DRUGS (Specify):
b. INDIVIDUAL ☒ WAS ☐ WAS NOT MENTALLY SOUND (Attach Psychiatric evaluation if appropriate).
c. INJURY OR DISEASE ☒ IS ☐ IS NOT LIKELY TO RESULT IN A CLAIM AGAINST THE GOVERNMENT FOR FUTURE MEDICAL CARE.
d. INJURY OR DISEASE ☒ WAS ☐ WAS NOT INCURRED IN LINE OF DUTY (Add basis for opinion in item 15).
e. CONDITION ☐ DID ☒ DID NOT EXIST PRIOR TO SERVICE AND ☐ WAS ☒ WAS NOT AGGRAVATED BY SERVICE.

12. THE FOLLOWING DISABILITY MAY RESULT
☐ NONE ESTIMATE OF TIME LOSS (Days):
☒ TEMPORARY ☐ PERMANENT PARTIAL ☐ PERMANENT TOTAL

13. BLOOD ALCOHOL TEST MADE ☐ YES ☐ NO

14. NO. OF MG ALCOHOL/100 ML BLOOD
N/A

15. DETAILS OF ACCIDENT OR HISTORY OF DISEASE (how, where, when)
Around 1445 hours, 23 Apr 89, PFC Doe was assisting in field artillery hasty displacement at firing point 20. He fell while loading M577 and sprained his right wrist.

16. DATE	17. TYPED OR PRINTED NAME OF ATTENDING PHYSICIAN OR PATIENT ADMINISTRATOR	18. SIGNATURE
23 Apr 89	John Q. Smith, MAJ, MD	John Q. Smith, MAJ, MD

SECTION II - TO BE COMPLETED BY UNIT COMMANDER OR UNIT ADVISER

19. DUTY STATUS
☒ PRESENT FOR DUTY ☐ ABSENT WITHOUT AUTHORITY
☐ ABSENT WITH AUTHORITY: ☐ ON PASS ☐ ON LEAVE

20. HOUR AND DATE OF ABSENCE

a. FROM	b. TO
N/A	N/A

21. ABSENCE WITHOUT AUTHORITY MATERIALLY INTERFERRED WITH THE PERFORMANCE OF MILITARY DUTY (Explain in item 30 type of duty missed, hours of duty, and how it did or did not interfere with performance)
☐ YES ☐ NO

22. INDIVIDUAL WAS ON
☐ ACTIVE DUTY ☒ ACTIVE DUTY FOR TRAINING
☐ INACTIVE DUTY TRAINING

23. HOUR AND DATE OF TRAINING

a. BEGAN	b. END
0600 22 Apr 89	1700 6 May 89

24. MEMBER WAS INJURED OR DIED OF INJURIES OR DISEASE PROCEEDING ☐ IN A DIRECT ROUTE ☐ IN AN INDIRECT ROUTE ☐ TO DUTY ☐ FROM DUTY.

25. MODE OF TRANSPORTATION	26. HOUR BEGINNING TRAVEL	27. DISTANCE INVOLVED	28. NORMAL TIME FOR TRAVEL
N/A	N/A	N/A	N/A

29. ADDITIONAL INSTRUCTIONS FOR INJURIES OR DEATHS CAUSED BY INJURIES RECEIVED IN ROUTE TO OR FROM TRAINING: INCLUDE MANNER OF TRAVEL, ROUTE FOLLOWED AND POINT OF INCIDENT IN ITEM 30. IF PROCEEDING FROM DUTY, INCLUDE RELEASE TIME AND DESTINATION ALSO.

30. FINDINGS BASED ON COMMANDER'S INVESTIGATION (Include names, SSNs and addresses of witnesses - continue on reverse if needed).
PFC Doe was loading a M577 Command Carrier for hasty displacement from firing point 20 Camp Roberts, CA. During the loading, PFC Doe slipped and fell from the top of the M577, landing on his right side and wrist. SM was evacuated to the Camp Roberts TMC, where it was determined that his right wrist was sprained. IN LINE OF DUTY.
SSG Paul W. Spencer, 987-65-4321, witnessed this accident. Address unknown.

31. FORMAL LINE OF DUTY INVESTIGATION REQUIRED	32. INJURY IS CONSIDERED TO HAVE BEEN INCURRED IN LINE OF DUTY (Not applicable on deaths)
☐ YES ☒ NO	☒ YES ☐ NO

33. DATE	34. TYPE NAME AND GRADE OF UNIT COMMANDER OR UNIT ADVISER	35. SIGNATURE
23 April 1989	CURTIS M. KELLEY, CPT, FA, CDR	Curtis M. Kelley, CDR

CAL ARNG Form 2173 1 JUN 88 TO BE USED IN PLACE OF DA FORM 2173 BY THE CALIFORNIA ARMY NATIONAL GUARD

APPENDIX D (continued)

CAMP-SB: John J. DOE, PFC
SSN: 001-22-0345

State of California, Military Dept.
OTAG, Sacramento, CA 95821 DATE: 3 May 89

APPROVED: (The reviewing authority and the approving authority are the same)

BY AUTHORITY OF THE SECRETARY OF THE ARMY

DENNIS E. BANOWETZ
MAJ, INF, CAL ARNG
Chief, Support Branch

APPENDIX D (continued)

STATE OF CALIFORNIA
OFFICE OF THE ADJUTANT GENERAL
P.O. Box 214405 - 2829 Watt Avenue
Sacramento, California 95821-4405

PERMANENT ORDERS 62-13 4 November 1988

HHC 1st Bde 40th Inf Div
HHC 2d Bn 160th Inf
Det 1 HHC 2d Bn 160th Inf
Co A 2d Bn 160th Inf
Co B 2d Bn 160th Inf
Co C 2d Bn 160th Inf
Co D 2d Bn 160th Inf
Det 1 Co D 2d Bn 160th Inf
Co E 2d Bn 160th Inf
HHC 3d Bn 160th Inf
Co A 3d Bn 160th Inf
Co B 3d Bn 160th Inf
Co C 3d Bn 160th Inf
Co D 3d Bn 160th Inf
Co E 3d Bn 160th Inf
HHC 1st Bn 185th Armor
Co A 1st Bn 185th Armor
Co B 1st Bn 185th Armor
Co C 1st Bn 185th Armor
Co D 1st Bn 185th Armor
HHB 2d Bn 144th FA
Btry A 2d Bn 144th FA
Btry B 2d Bn 144th FA
Btry C 2d Bn 144th FA
Svc Btry 2d Bn 144th FA
HHD 40th Spt Bn
Co A 40th Spt Bn
Co B 40th Spt Bn
Co C 40th Spt Bn
Det 2 Co A 132d Engr Bn
40th Pers Svc Co

The Army National Guard unit shown and its members are ordered to annual training for the period indicated and will proceed from home station to duty station shown. Upon completion of annual training, return to home station and terminate annual training status.

Authority: NGB Training Authority CA-11 FY 89, 32 USC 503 and Sections 142 and 368 California Military and Veterans Code
Duty station: Camp Roberts CA
Period: 22 Apr - 6 May 89 (15 days including travel time) TDC: 101
Accounting classification: Off Pay & alw 2192060 18-1004 P1A10.1000-1100,1200 S04376
Off Tvl & PD 2192060 18-1004 P1A50.1000-2100 S04376
EM Pay & alw 2192060 18-1004 P1A30.1100-1100,1200 S04376
EM Tvl & PD 2192060 18-1004 P1A60.1100-2100 S04376
Additional instructions: Payrolls will be accomplished in accordance with instructions contained in CAL ARNGR 350-5. Units are authorized group travel by commercial charter bus if appropriate. Accounting classification:

APPENDIX D (continued)

Permanent Orders 62-13 OTAG 4 Nov 88

Officer travel 2192060 18-1004 P1A50.1000 216C S04376. EM travel 2192060 18-1004 P1A60.1100 216C S04376. Units are authorized group travel by commercial air if appropriate. Accounting classification: Officer travel 2192060 18-1004 P1A50.1000 217C S04376; EM travel 2192060 18-1004 P1A60.1100 217C S04376.
Duty is considered Field conditions, and reimbursement for per diem will be in accordance with JTR VOL 1, Para M6000(1)(a)(3)(1)
Individuals are required to submit Request for Orders (NGB Form 102-10/ DD Form 1610) to CAOT-TO IAW CAL ARNGR 310-4 when travel and per diem are required.
Format: 250

BY ORDER OF THE GOVERNOR:

STATE OF CALIFORNIA
OFFICIAL COPY
MILITARY DEPARTMENT

ANDREW G. WOLF, JR.
COLONEL, FA, CA ARNG
Director of Administration

DISTRIBUTION:
D

APPENDIX E

APPENDIX E (SCIF)

HEADQUARTERS 143D EVACUATION HOSPITAL
California Army National Guard
Armed Forces Reserve Center
Los Alamitos, California 90720

MBEH-A-AJ 15 May 1990

MEMORANDUM FOR The Adjutant General, State Military Department, ATTN: CAMP-SB, Sacramento, CA 95821

SUBJECT: Request for State Compensation

1. Request that your office take action to award temporary State Compensation Insurance Fund benefits (SCIF) to Staff Sergeant Robert Amiga, 545-71-5678, this organization.

2. Staff Sergeant Amiga was injured on 15 May 1990 during a field exercise and has been unable to return to work. Although a line of duty is being processed there have been additional problems with his civilian employer that will delay the incapacitation payroll request. SSG Amiga is in need of immediate financial assistance to pay his bills and support his family.

3. Staff Sergeant Amiga has been counseled that if this request is approved any SCIF financial assistance (temporary disability payments) must be repaid upon receipt of federal incapacitation pay as required by law; he has agreed to do so and a repayment agreement is enclosed.

4. All available documents have been enclosed for your review.

Deborah Snats

DEBORAH M. SNATS
CPT, MC, CA ARNG
Adjutant

Encl
as

CF: Cdr, 175th Med Bde

APPENDIX E (continued)

PLEASE TYPE ALL INFORMATION, IF POSSIBLE

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS	Please complete in triplicate. Retain last copy for your files and mail the original and one copy to **STATE COMPENSATION INSURANCE FUND** P.O. BOX 807 SAN FRANCISCO, CA 94101-0807 Telephone: (415) 565-1344	OSHA Case or File No.

PICA [X][X][X] ELITE [Y][X][X] ← TYPEWRITER ALIGNMENT GUIDE → PICA [X][Y][X] ELITE [X][Y][X]

California law requires an employer to report **within five days** every industrial injury or occupational disease which: (a) results in lost time beyond the day of injury, or (b) requires medical treatment other than first aid. **PLEASE NOTE:** In addition, if death results or if the injury or illness: (a) requires inpatient hospitalization of more than 24 hours for other than medical observation; or (b) results in loss of any member of the body; or (c) produces any serious degree of permanent disfigurement, then the nearest district office of the California Division of Occupational Safety and Health also must be notified **immediately** by telephone or telegraph. This notification is not required, however, if the injury or death results from an accident on a public street or highway.

EMPLOYER

1. FIRM NAME — DIVISION: STATE OF CALIFORNIA - MILITARY DEPARTMENT
1A. POLICY NUMBER
2. MAILING ADDRESS (Number and Street, City, ZIP): P.O. BOX 214405, Sacramento, CA 95821
2A. PHONE NUMBER
3. LOCATION, IF DIFFERENT FROM MAIL ADDRESS (Number and Street, City, ZIP)
3A. LOCATION CODE
4A. NATURE OF BUSINESS e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.: MILITARY
5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.
4B. TYPE OF EMPLOYER: PRIVATE | STATE: X | CITY | COUNTY | SCHOOL DISTRICT | OTHER GOVERNMENT — SPECIFY

EMPLOYEE

6. EMPLOYEE NAME: AMIGA, ROBERT
7. DATE OF BIRTH (MM-DD-YY)
8. HOME ADDRESS (Number and Street, City, ZIP): 6312 Commodore Drive, Los Alamitos, CA 90720
8A. PHONE NUMBER
9. SEX: Male: X | Female
10. OCCUPATION (Regular job title, not specific activity at time of injury): Medic (Military)
11. SOCIAL SECURITY NUMBER
12. DEPARTMENT IN WHICH REGULARLY EMPLOYED: State Military Department
12A. DATE OF HIRE (MM-DD-YY)
13. HOURS USUALLY WORKED: HOURS PER DAY: 8
13A. DAYS PER WEEK
13B. TOTAL WEEKLY HOURS
13C. Under what class code of your policy were wages assigned?
14. GROSS WAGES/SALARY: 1750 PER: HOUR | DAY | WEEK | TWO WEEKS | MONTH | OTHER — SPECIFY

INJURY OR ILLNESS

15. WHERE DID ACCIDENT OR EXPOSURE OCCUR? (Number and Street, City): Camp San Luis Obispo, CA
15A. COUNTY
15B. ON EMPLOYER'S PREMISES? YES: X | NO
16. WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using.): Loading a truck with Field Equipment
17. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.): Sergeant Amiga was lifting a 50 lb box of equipment and injured his back.
18. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE e.g., the machine employee struck against or which struck him; the vapor or poison inhaled or swallowed; the chemical that irritated his skin; in cases of strains, the thing he was lifting, pulling, etc.
19A. DESCRIBE THE INJURY OR ILLNESS e.g., cut, strain, fracture, skin rash, etc.: back strain
19B. PART OF BODY AFFECTED e.g., back, left wrist, right eye, etc.: lower back
20. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)
21. IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)
22. DATE OF INJURY OR ILLNESS (MM-DD-YY): 05 15 90
23. TIME OF DAY: 930 a.m.: X | p.m.
24. Did employee lose at least one full day's work after the injury? NO: X | YES — Date Last Worked (MM-DD-YY): 05 15 90
25. HAS EMPLOYEE RETURNED TO WORK? (MM-DD-YY) No, still off work: X | Yes, date returned:
26. DID EMPLOYEE DIE? NO: X | YES — Date of Death (MM-DD-YY):
27. WAS ANOTHER PERSON RESPONSIBLE? NO: X | YES
28. WAS INJURED AN EXECUTIVE OFFICER OR A PARTNER? NO: X | YES

Completed by (type or print)	Signature	Title	Date

PLEASE DO NOT USE THIS COLUMN
CASE NO.
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
ACCIDENT TYPE
A.O.S.
EXTENT OF INJURY
CODED BY

SCIF 3067 (REV. 8-88)

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. NOTICE OF WORKERS' COMPENSATION BENEFITS MUST BE GIVEN TO INJURED WORKER WITHIN 5 DAYS OF YOUR KNOWLEDGE OF THIS INJURY.

FORM 5020 (REV. 5) April 1987

APPENDIX E (continued)

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

NAME	DATE OF INJURY OR ILLNESS	TIME OF DAY
Robert Amiga	15/ 05 /90	0930 [X] A.M. [ ] P.M.

HOME ADDRESS (Number, Street, City, Zip Code)
6312 Commodore Drive, Los Alamitos, CA 90720

WHERE DID ACCIDENT OR EXPOSURE OCCUR (Number, Street, City, Zip Code)
Camp San Luis Obispo, CA 93403

DESCRIBE THE INJURY OR ILLNESS AND HOW IT OCCURRED

Our unit was involved in a field exercise at CSLO. We wre loading equipment on a truck when I felt a sharp pain in my back. I was unable to continue to work and reported this injury to the first sergeant.

NOTICE OF POTENTIAL ELIGIBILITY FOR BENEFITS

You may be entitled to one or more of the following benefits provided for you at your employer's expense, depending upon your individual situation: medical treatment, compensation for lost time related to this injury, compensation for a permanent impairment, vocational rehabilitation, and/or death benefits. Compensation is based on a percentage of your earnings. If you are hospitalized or off work for more than 3 days as a result of this injury, you will receive your first payment of compensation or a notice within 14 days of your employer's notice or knowledge of this injury. Along with your first payment, you will also receive a pamphlet describing more fully compensation benefits and procedures.

YOU MUST FILE THIS CLAIM FORM WITH YOUR EMPLOYER TO PROTECT YOUR RIGHTS

Failure to file this claim form will preclude you from receiving any late payment penalty that may be due and will also preclude your right to pursue further legal remedies.

If you need assistance in completing this form or have any questions regarding your work injury you may contact the State of California Office of Benefit Assistance and Enforcement by calling 1/ (415) 557-1954. This service is provided to you at no cost . You also may consult an attorney.

I gave this form to my employer on (date) 15 May , 19 90 .

EMPLOYEE: Keep copy marked "EMPLOYEE'S TEMPORARY RECEIPT " until you receive the dated copy from your employer.

EMPLOYER FILLS OUT THIS PART

Date of knowledge of injury	Date claim form was provided to employee	Date claim form was received
05 / 15 / 90	05 / 15 / 90	05 / 15 / 90

Name of Employer
CAL NATIONAL GUARD, HQ 143d EVAC Hospital

Signature of Employer/Representative
Deborah Suits

Employer: You are required to date this form and provide copies as marked, to your insurer and to the employee, dependent or agent who filed the claim.
Signing this form does not necessarily constitute acceptance of a claim.
Please return original to your local State Fund office.

STATE COMPENSATION INSURANCE FUND

SCIF 3301 (NEW 1-90)

STATE FUND COPY